

## MARYLAND HEALTH CARE COMMISSION

### *UPDATE OF ACTIVITIES*

October 2009

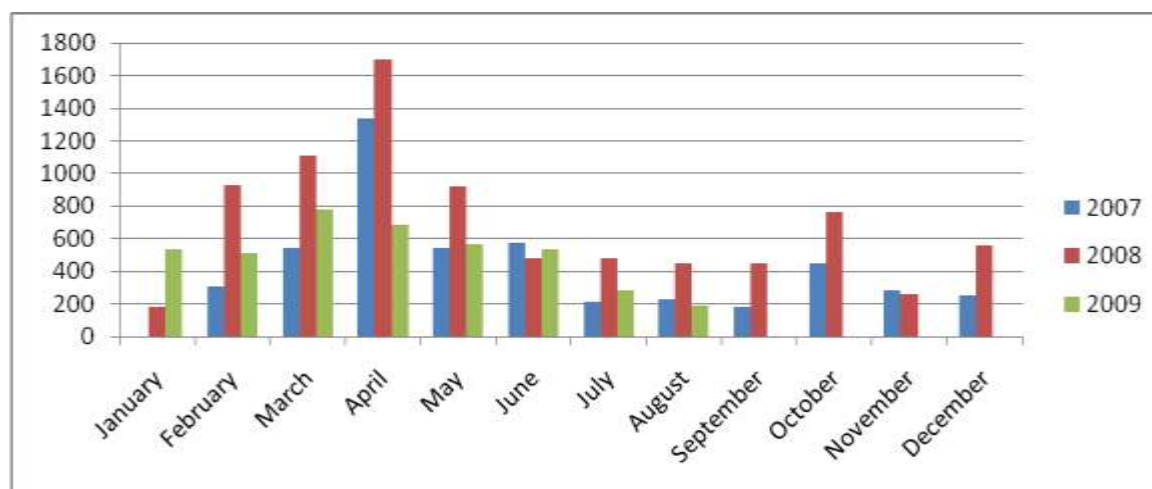
#### **CENTER FOR INFORMATION SYSTEMS AND ANALYSIS**

#### **Maryland Trauma Physician Services Fund**

##### **Uncompensated Care Processing**

CoreSource, Inc., the third party administrator (TPA) for the Trauma Fund, adjudicated claims with a total paid value of approximately \$193,355 in August. The monthly payments for uncompensated care since February 2007 are shown below in Figure 1.

**Figure 1 – Uncompensated Care Payments 2007-2009**



#### **Patient Centered Medical Home Workgroup**

The Maryland Health Quality and Cost Council met on October 1, 2009. Council member Barbara Epke and Ben Steffen, the Commission's Director of Information Systems and Analysis, updated the Council on the Patient Centered Medical Home Workgroup's recommendations for a multi-stakeholder PCMH demonstration pilot project. The Council approved all recommendations made by the Workgroup. The next meeting of the PCMH Workgroup will be held on October 26, 2009, from 3:30 to 5:00 p.m. in the Commission's Room 100. Information regarding the work of each of the subgroups and the Workgroup, as well as the schedule of upcoming meetings, is available on the Council's website at: <http://dhmh.state.md.us/mhqcc/pcmh.html>.

## *Cost and Quality Analysis*

### **Maryland Medical Care Data Base (MCDB) and Data Collection Regulations**

In 2007, the Maryland General Assembly passed House Bill 800 (HB 800), Maryland Health Care Commission – Program Evaluation, (2007 Laws of Maryland, Chapter 627), which authorized the MHCC to expand the scope of information of the Maryland Medical Care Data Base (MCDB) to include information on institutional services (primarily hospital inpatient and outpatient charges), demographic characteristics of the enrollees, and insurance contract information typically collected by the carrier at enrollment in the plan. These data, when merged with information on physician services and prescription drugs, will allow the Commission to provide a more complete picture of health care utilization and spending for Maryland residents. Longer term, the demographic information will enable MHCC and the Department of Health and Mental Hygiene to better assess health disparities in Maryland. The data base expansion will also bring Maryland's data collection more in line with similar initiatives now underway in Massachusetts, New Hampshire, Vermont, and Maine.

On September 11, 2009, the Commission released, for informal public comment, proposed replacement regulations (COMAR 10.25.06: Maryland Medical Care Data Base and Data Collection, Regulation .01 - .18) to modify and expand the MCDB reporting requirements for payers under existing regulations (COMAR 10.25.06: Maryland Medical Care Data Base and Data Collection, Regulation .01 - .14). The comments were due to the Commission on September 25, 2009, and comments were received from 13 organizations and individuals, including our data base vendor, Social and Scientific Systems, DHMH, the Maryland Insurance Administration, and nine payers. Given the large volume of comments, staff will need additional time to research the suggestions for additional variables and summary reports and to hold a conference call with the payers and SSS to discuss the suggested revisions. As a result, promulgation of the proposed replacement regulations has been rescheduled for the November Commission meeting.

### **MCDB Contract Activities**

Staff held two meetings with our data base vendor, Social and Scientific Systems (SSS), during the month of September. One meeting was dedicated to discussing ways in which the data collection and processing could be made more efficient over the next five years through automating certain aspects of the collection and processing. The second meeting addressed plans for the new Health Care Expenditure Comparisons (HCEC) report, which is discussed below.

### **Health Care Expenditures Comparison (HCEC) Report**

This report will replace the State Health Expenditure Account (SHEA) report that has been published annually by MHCC. MHCC staff aims to address some of the same themes and provide comparative information with other states in a less labor intensive manner. Unlike the SHEA, which required extensive (and expensive) data collection and made comparisons only to the nation as a whole, the HCEC will make use of publically available expenditure data to identify important differences in health care spending in Maryland as compared to other states, especially states which rank as good or better than Maryland in (published) measures of health care quality. The major tradeoff will be that most of the data will be from already published sources and thus less timely.

The HCEC report will have a similar appearance to past SHEAs in that discussions will be built around a series of charts that display data on health care spending in Maryland. The major additional will be comparisons will be made to the US and other states similar states.

## Health Insurance Coverage

At the end of August, the Census Bureau released health insurance coverage data for the nation in 2008 and for each state in 2007-2008 (for states, at least two years must be combined due to sample sizes), based on data from the Current Population Survey (CPS). The results were somewhat counterintuitive in that the expected upturn in the number of uninsured did not occur. On a surprisingly positive note, the number of uninsured (all ages) in Maryland in 2007-2008 was virtually unchanged at 715,000.

Using the recommended two-year averages, the uninsured rates have been stable from 2005-2006 to 2007-2008. For the under 65 population, the 2007-2008 rate (14.4 %) was statistically the same as 2005-2006, but higher than in 2000-2001 (12%). The two-year average private and public rates in the under 65 population also stabilized:

- Medicaid rate: 6% (2000-01); 7% (2002-03); 9% (2004-05, 2006-07); 10% (2007-2008)
- Private rate: 83% (2000-01); 78% (2002-03); 76% (2004-05, 2006-07, 2007-08).

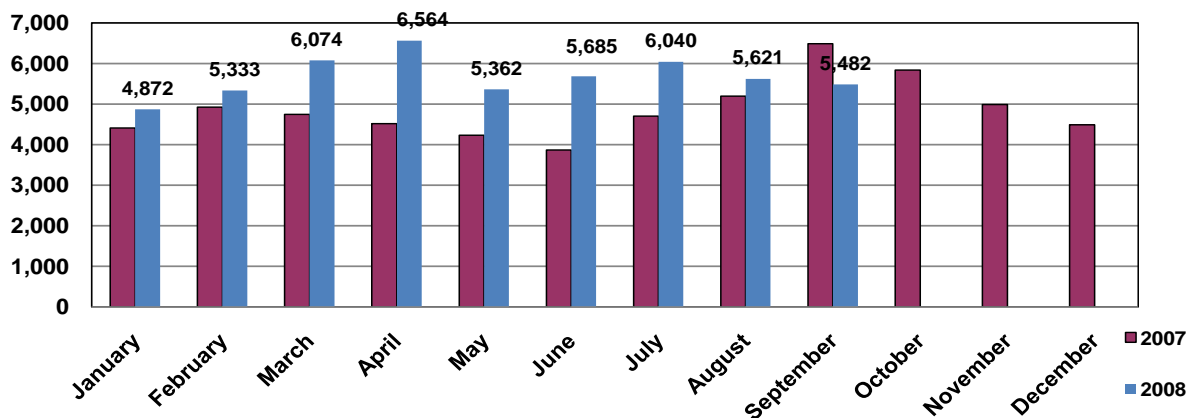
The one year, all ages rates—in spite of small sample sizes and relatively high margins of errors of the estimates—show a significant decrease in the percent uninsured from 2007 to 2008 (13.7% to 12.1%), and a significant increase in Medicaid coverage (9.1% to 10.7%), verified with Medicaid enrollment data. The decline in the percent uninsured may be due to the way the question on insurance coverage is framed. Respondents are asked to identify their sources of insurance coverage in the previous year. Individuals that report no coverage at any time during the previous year are classified in the CPS as uninsured.

## Data and Software Development

### Internet Activities

As noted in the September progress report, staff changed its web analytics vendor in July from Analytics ClickTraks Software to Google/Analytics. Google/Analytics is available at no cost as compared to a \$1,000 annual subscription charge from ClickTraks. ClickTraks also informed MHCC that they do not anticipate making further enhancements to their software. Google offers most of the capabilities, and given that ClickTraks is not making any enhancements, the conversion decision was easy.

Figure 2 -- Unique Visitors to the MHCC Web Site



Google/Analytics uses different methodologies for many of the web analytics typically reported to the Commission. Most importantly, Google/Analytics does not count visitors or unique users in the same way as ClickTraks. Our visitor and unique user counts are lower using the Google product. We expect to provide a full array of information on visits to the MHCC site for the October reporting month. This month, we will only provide a limited amount of information. The number of visitors to the MHCC web site declined by 7.2 percent from 12,734 in July to 11,815 in August. The number of unique visitors fell by an identical percent from 6,040 in July to 5,621 in August. Several other metrics were more positive. Average time on the site increased by about 5 percent and the number of pages viewed per visitor also increased. Information on electronic health vendors, assisted living, and hospital quality were accessed the most frequently.

### **Web Development for Internal Applications**

Staff continued to make progress on license renewal applications for the occupation boards. Table 1 presents the status of development for internal applications and for the health occupation boards. The current workload and the limited staff available for development has forced MHCC to scale back support to the boards in the last several months. In the upcoming months, MHCC staff will add several new capabilities to the web site, the first of which will be a listserv capability slated to be added later this fall.

Another particularly noteworthy development was the implementation of the renewal feature in the web-based Partnership application. Employers that have been in the program successfully renewed policies and subsidy payments were calculated beginning for renewals as of October 1.

**Table 1– Web Applications Under Development**

<b>Board</b>	<b>Anticipated Start Development/Renewal</b>	<b>Start of Next Renewal Cycle</b>
Board of Physicians – Physician Renewal	Production	July 2009
Chiropractic Examiners	Production	September 2009
Nursing Home/Long Term Care Survey	Production	July 2009
Partnership	Modifications	October 2009
Nursing Home/Long Term Care Survey Development	Development Underway	January 2010
Nursing Home Quality Site	RFP Planned	Start of Project, November 2009
MHCC Listserv	Development	Availability October 15th
AHRQ QI Installation	Planning	Delayed

<b><i>CENTERS FOR HEALTH CARE FINANCING AND LONG-TERM CARE AND COMMUNITY BASED SERVICES</i></b>
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**HMO Quality and Performance**

The 2009 Health Plan Performance Report has been completed and will be posted on the website at the conclusion of the Commission meeting. An embargoed press release has been distributed to the media statewide for release at the conclusion of the meeting. This is the second year that PPOs have been included in the report. The report was converted from print (some 90,000 copies per year) to a web-based report. Marylanders who do not have access to the internet can call the MHCC toll free number and be referred to a staff member who assists them in getting the information they seek.

We are currently recruiting to fill the vacant division chief position. Applications are being received through COB October 19.

This is the time of the year in which the MHCC issues its Proposed Reporting Requirements for Maryland Commercial HMOs and PPOs. A draft of the requirements was forwarded to the health plans on September 24, some 30 days earlier than in previous years. This has been very well received by the health plans and will be standard practice in the future. There are seven plans again this year that meet COMAR 10.25.08 requirements for HMO reporting to the Commission:

- Hold a certificate of authority in Maryland;
- Report over \$1 million in written premium volume in Maryland based on the annual statement submitted to the Maryland Insurance Administration (MIA) during the calendar year preceding the reporting period; and
- Less than 65% of its Maryland enrollees receive coverage through the Medicaid and Medicare programs, as reported in the annual statement submitted to the MIA during the calendar year preceding the reporting period.

PPOs are not required to report to the Commission but three health plans Aetna, CareFirst, and CIGNA have been participating in a pilot using many of the same measures as are used for the HMOs.

On October 6, 2009, staff held a conference call with the health plans and the MHCC contract auditor to discuss the 2010 proposed reporting requirements. All questions and concerns were addressed at that time. Plans need several weeks to pull member files for audit review. A formal kickoff meeting for the audit review cycle will be held in early December.

**Small Group Market**

**Comprehensive Standard Health Benefit Plan (CSHBP)**

As reported in May, carriers participating in the small group market are required to annually submit to the Commission completed survey forms that include enrollment and premium information in the CSHBP for the preceding calendar year. As part of the actuarial contract, Mercer is required to audit the survey forms submitted by the major small group carriers. As a result of this year's audit, Mercer determined, and the dominant carrier reported to the MHCC, that the reporting method used for some portions of their book of business, though acceptable, differed from the method historically used. As a result, that carrier submitted revised survey forms for their PPO and PPO/H.S.A. products for calendar year 2008. Staff presented this updated premium information at the September meeting and the updated report is posted on the MHCC website.

With the enactment of HB 610, Bona Fide Wellness Program Incentives, the Commission adopted final regulations at the September meeting so that the wellness regulations (COMAR 31.11.14) comply with this new law while maintaining a provision currently in these regulations to ensure that the components of a wellness benefit include a health risk assessment, written feedback to those who complete the health risk assessment, and a financial incentive to promote preventive care, healthy behavior, or participation in a disease management or case management program. The regulations will be implemented effective October 19<sup>th</sup>.

With the enactment of SB 637/HB 674, the Commission is required to study (1) options to implement the use of value-based health care services and increase efficiencies in the CSHBP; and (2) potential options for allowing plans with fewer benefits than the Standard Plan. This report is due by December 1, 2009. This Act also requires the Commission to post on the MHCC website and update quarterly premium comparisons of health benefit plans issued in the small group market. This is currently a work in progress.

### **Health Insurance Partnership**

The premium subsidy program known as “The Partnership” has been available to certain small employers with 2 to 9 full time employees since October 1, 2008. As of October 6, 2009 enrollment in the Partnership was as follows: 221 businesses; 622 employees; 1,003 covered lives. The average annual subsidy per enrolled employee is \$1,878; the average age of all enrolled employees is 39; the group average wage is \$27,587; the average number of employees per policy is 3.8; and the total subsidy amount issued is about \$1.1 million.

At the September public meeting, the Commission adopted as final, a few changes to the Partnership regulations along with updates to the Program Design Factors, including a new maximum subsidy table. The updated Program Design Factors were posted on the Partnership website prior to August 1<sup>st</sup> and became effective on October 1, 2009. The emergency regulations became effective on July 16<sup>th</sup> and expire on November 18<sup>th</sup>. The final regulations will be implemented effective October 19<sup>th</sup>.

Commission staff continually updates the Partnership website (<http://mhcc.maryland.gov/partnership>) to inform all interested parties, including, carriers, producers, employers, employees, various business associations, etc. about this subsidy program. As required in statute, staff will prepare the second annual report on the implementation of the Partnership by January 1, 2010.

### **Mandated Health Insurance Services**

Insurance Article § 15-1501, Annotated Code of Maryland, requires the Commission to submit an annual report to the General Assembly on: (1) any proposed mandated health insurance service that failed during the preceding legislative session; and (2) any request for analysis on a proposed mandated benefit that was submitted by a Legislator to the Commission by July 1<sup>st</sup> of that year. Each evaluation must include an assessment on the medical, financial, and social impact of the proposed mandate. The 2008 report, prepared by the Commission’s consulting actuary (Mercer) and approved by the Commission for submission to the General Assembly, included an evaluation on the following five (5) proposed mandates: coverage for prosthetic devices; extending the current mandate on coverage for in vitro fertilization (IVF); coverage for the shingles (herpes zoster) vaccine; coverage for autism spectrum disorder; and coverage for a 48-hour inpatient stay following a mastectomy. Earlier this month, staff received a request to again review coverage for autism spectrum disorder since changes to last year’s bill will be proposed which remove the age and monetary limitations. Staff has forwarded the proposed legislation to Mercer for a limited review to include the medical and fiscal impact of these changes. In addition, staff recently received a request to review eligibility for IVF coverage after 1 year of infertility versus the current mandate which allows coverage after 2 years of infertility. Mercer will evaluate the fiscal impact of these changes.

## **Long Term Care Policy and Planning**

### **Hospice Data**

Data collection and data cleaning for the FY 2008 Maryland Hospice Survey have been completed. In addition to the public use data set for FY 2008, a new Trend Analysis Report for FY 2005-2008 has also now been posted on our website.

### **HB 30 Workgroup**

Long Term Care staff has been asked to participate in the HB 30 Workgroup. The mission of the workgroup is to study: the types of options available in the state for hospice and palliative care; the degree to which these options are utilized within home, long term care, hospital and hospice settings; the average length of time spent in various settings; and the types and degree of barriers that exist regarding awareness of, and access to hospice and palliative care programs. A meeting was held on September 24 to review a draft report and to discuss recommendations.

### **Minimum Data Set**

Staff is currently working with the minimum data set (MDS) Resident Assessment Instrument to update data sets for planning and policy development. The focus is on: update current programs and address programming issues; construct variables for research projects; develop a methodology to impute missing data; create data sets that permit tracking of variables over time; and link data sets. The most recent conference call was held on September 16<sup>th</sup>.

### **Long Term Care Presentation**

Staff attended the combined Lifespan and Health Facilities Association of Maryland conference to make a presentation on October 1, 2009. The theme of the conference was “Surviving the Storm”, dealing with the numerous financial, quality and other issues faced by the Long Term Care industry. Staff’s presentation was to inform the providers of the tools available on the Commission’s website, including many long term care reports as well as public use data sets derived from the Commission’s surveys. Staff presented resident profiles for nursing home, assisted living, hospice, and home health agency settings. Staff also presented analysis of nursing home data from the Long Term Care Survey.

### **Home Health Agency Data Analysis**

Commission staff continues to review and analyze utilization trend data of HHA services. Staff is looking at age-specific use rates, as well as jurisdiction-specific utilization patterns in order to determine possible changes to the methodology for forecasting home health agency need. Preliminary analysis of Medicare and Medicaid home health utilization by zip code has also been part of the home health agency data analysis.

### **Home Health Survey**

Staff continues to finalize the Health Home Agency Survey Updates. Staff expects to have the survey available for data entry by the end of October 2009.

### **Long Term Care Survey**

As of October 5, 2009, 99% of the facility surveys have been submitted and accepted by the Commission. Surveys were made available for online data entry as of June 9, 2009. The due date for survey completion was August 20, 2009. In response to an appeal by Lifespan Network (Long Term Care Association), the Executive Director, in a letter dated August 20<sup>th</sup>, extended the due date to September 20, 2009 but notified providers that as of October 1, 2009 fines would be imposed for late submission. On October 5, 2009 the Executive Director issued letters imposing fines to seven facility providers who had not yet completed the 2008 Maryland Long Term Care Survey. Fines began to accrue from October 1<sup>st</sup>, 2009 as mentioned in the extension letter from the Executive Director dated August 20, 2009.

## *Long Term Care Quality Initiative*

### **LTC Website Expansion**

The LTC Advisory Committee has received the site specifications for review and comment on basic design and functionality.

### **Other Activities**

- 1) Staff made a Power Point presentation to participants in the annual conference sponsored by LifeSpan Network and the Health Facilities Association of Maryland titled “Tools for Surviving the Storm”. Presentation content included the proposed transition of the LTC web site to incorporate expanded information on in-home and community services in addition to enhanced nursing home and assisted living guides.
- 2) The MHCC participated as an exhibitor at the Baltimore Senior Expo held October 7-8, 2009. Visitors to the booth were able to learn about features in the current Nursing Home and Assisted Living Guide, preview the proposed web site, and provide feedback on the new site. Visitors were also exposed to the breadth of functions performed by the MHCC.
- 3) Nursing home family and resident surveys are in the data collection phase.

## ***CENTER FOR HOSPITAL SERVICES***

### *Hospital Services Planning and Policy*

#### *Certificate of Need (CON): September 1, 2009 through September 30, 2009*

#### **CONs Issued**

Rivermont Nursing & Rehabilitation Center (Montgomery County) – Docket No. 08-15-2228  
Establishment of a 124-bed comprehensive care facility (“CCF”) on a 4-acre site located on the south side of the Route 121 (Clarksburg Road) immediately west of Route 121 interchange with Interstate 270 in Clarksburg.

(The beds which will be operated at this facility include 80 beds formerly operated at Mariner Health of Circle Manor, Silver Spring, and 44 beds currently operated at Springbrook Nursing and Rehabilitation Center (“Springbrook”), Silver Spring.)

Cost: \$35,699,459

Fairland Nursing & Rehabilitation Center (Montgomery County) – Docket No. 09-15-2291  
Replace and relocate an existing 92-bed CCF, located at 2101 Fairland Road in Silver Spring, with a 167-bed CCF on a 3.6 acre site located at 12110 Plum Orchard Drive, Silver Spring.

(The beds which will be operated at this facility include the 92 beds currently licensed at the facility to be relocated, 20 beds formerly operated at Holy Cross Hospital, Silver Spring, 8 beds formerly operated at Bethesda Health and Rehabilitation Center, Bethesda, 4 beds formerly operated at Springbrook, and 43 beds currently operated at Springbrook.)

Cost: \$38,505,713

Frederick Surgery Center (Frederick County) – Docket No. 09-10-2296

Replace and relocate an existing ambulatory surgical facility, located at 915 Toll House Avenue, Suite 103, in Frederick, with an ambulatory surgical facility to be located in leased space at 45 Thomas Johnson Drive, in Frederick

The existing facility has four sterile operating rooms and four non-sterile procedure rooms. The replacement facility will have the same room inventory.

Cost: \$2,429,540

### **Modified CONs Issued**

St. Mary's Hospital (St. Mary's County) – Docket No. 08-18-2248

Reduce the scope of an expansion and renovation project approved on November 5, 2008.

Overall, the amount of newly constructed or renovated space approved in 2008 is being reduced by 33% (from 205,330 square feet ["SF"] to 137,299 SF). The reduction in new construction SF is 53% (140,570 to 65,944 SF). The amount of space to be renovated will increase by 10% from 64,760 to 71,355 SF.

Physical capacity for 26 of the 32 approved additional beds is eliminated, including 18 additional medical/surgical/gynecological/addictions beds, six additional obstetric beds, and two additional psychiatric beds. The emergency department will have 43 treatment spaces upon completion of the project, as modified, instead of the 53 spaces approved in 2008. The estimated cost of the project, as modified, is \$56,126,328, a reduction of 37% from the \$89,126,328 approved cost of the original project. Bond debt as a source of funds will be reduced from \$79,611,972 (89.3% of total project cost) to \$51,695,000 (91.8% of total project cost). Projected interest earnings on bond proceeds (a source of project funding) will be reduced from \$2,721,140 (3.1% of total project costs) to \$1,042,945 (1.9% of total project cost). The cash contribution to project funding will be reduced from \$4,993,317 (5.6% of total project cost) to \$1,768,817 (3.1% of total project cost).

Cost: \$56,126,328

### **CON Applications Withdrawn**

Delmarva Surgery Center (Cecil County) – Matter No. 09-07-2299

Establishment of an ambulatory surgical facility (through addition of a second operating room at an ambulatory surgical center with one sterile operating room) to be located at 101 Chesapeake Boulevard, Suite C, Elkton.

Estimated cost: \$217,000.

### **Pre-Licensure/First Use Approval Issued (Completion of CON-Approved Projects)**

Doctor's Community Hospital (Prince George's County) – Docket No. 05-16-2163

Expansion and renovation including a 6-story building addition and expansion of the emergency department

Partial First Use – Completion of building addition housing MSGA beds

September 1, 2009

Baltimore Washington Medical Center (Anne Arundel County) – Docket No. 04-02-2154

Expansion and renovation including an 8-story building addition, expansion of the emergency department, introduction of obstetric inpatient services and a Level II perinatal service program and an increase in physical bed capacity from 292 to 342 beds.

Cost: \$134,607.479

Final First Use

September 30, 2009

### **CON Letters of Intent**

Physicians Surgery Center of Frederick ["PSCF"] (Frederick County)

Establishment of an ambulatory surgical facility (through addition of a second operating room at an ambulatory surgical center with one sterile operating room) to be located at 81 Thomas Johnson Court in Frederick and closure of an ambulatory surgical facility, Fredericktown Ambulatory Surgical Center,

located at 198 Thomas Johnson Drive, Suite 101, in Frederick (merging with PSCF)

### **CON Letters of Intent Withdrawn**

Chiaromonte Health Care Enterprises (Prince George's County)  
Construction of a 150 bed acute care hospital at the Bowie Health Center campus, 15001 Health Center Drive, Bowie

### **Determinations of Coverage**

- **Ambulatory Surgery Centers**

Piccard Surgery Center (Montgomery County)  
Establish an ambulatory surgery center with 1 sterile operating room ("OR") and 2 non-sterile procedure rooms to be located at 1330 Piccard Drive, Suite 102, Rockville

SurgCenter of Greenbelt (Prince George's County)  
Establish an ambulatory surgery center with 1 sterile OR and 1 non-sterile procedure room to be located at 7300 Hanover Drive, Suite 102, Greenbelt

Timonium Surgery Center (Baltimore County)  
Establish an ambulatory surgery center with 1 sterile OR and 1 non-sterile procedure room to be located at 1954 Greenspring Drive, Suite LL18, Timonium

Maryland Podiatry Center (Howard County)  
Establish an ambulatory surgery center with 1 non-sterile procedure room to be located at 3460 Ellicott Center Drive, Suite 103, Ellicott City

- **Other**

- **Delicensure of Bed Capacity or a Health Care Facility**

Montgomery Village Health Care Center (Montgomery County)  
Temporary delicensure of 25 CCF beds

### ***Hospital Planning & Policy***

On September 8, 2009, Center for Hospital Services ("CHS") staff met with representatives of the Maryland Ambulatory Surgery Association to discuss plans for surveying influenza immunization levels among the staff of Maryland's ambulatory surgical facilities and centers.

CHS staff participated in several September meetings of the Maryland Institute for Emergency Medical Services Systems Intensive Care Unit Surge Capacity Work Group. This work group is providing guidance to the contingency planning efforts of hospitals in anticipation of their need to handle higher than normal levels of demand for emergency medical treatment and admissions during the Fall of 2009 and the Winter of 2009/2010 related to epidemic levels of H1N1 influenza virus incidence and prevalence. The Work Group is also developing a system for monitoring increases in demand in order to trigger varying levels of hospital contingency plan implementation, at the institutional, regional, or statewide level. CHS staff have served as a resource on hospital service capacity and prevailing levels of demand that can serve as a baseline for monitoring.

## *Hospital Quality Initiatives*

### **Hospital Performance Evaluation Guide (HPEG) Advisory Committee**

The HPEG Advisory Committee held its monthly meeting in September and continues to provide guidance on the various activities associated with the maintenance and expansion of the Hospital Performance Evaluation Guide (HPEG). Over the past month, the HPEG Committee has focused on issues surrounding the implementation of the new Quality Measures Data Center (QMDC), considered and approved proposed measures for inclusion in the Guide and reviewed the progress on HAI data collection and reporting activities. Most recent accomplishments are highlighted below:

#### ■ *Hospital Performance Evaluation Guide Updates and New Measures*

There are several enhancements to the Hospital Performance Evaluation Guide planned over the next few months. These enhancements include the addition of patient experience data, mortality data and information on healthcare associated infections. By January 2010, the staff plans to include patient experience data collected through the Hospital – Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey as well as CMS mortality data for AMI, Heart Failure and Pneumonia on the Hospital Guide. Information on active surveillance testing for MRSA in ICUs is also planned for inclusion in the Guide early next year. MHCC has engaged the services of the Iowa Foundation for Medical Care (IFMC) to facilitate the implementation of this project. The staff has been working with IFMC on the development of the timeframe, process and format for display of these new measures on the Guide.

Effective October 1, 2009, the MHCC expanded the process measures data reporting requirements to include PN-7, Percent Pneumonia Patients Assessed and given Influenza Vaccination (Reported by Flu Season ONLY). Effective January 1, 2010 the MHCC will expand the process measures data reporting requirements to include AMI-8, Percent of Heart Attack Patients Given PCI within 90 minutes of Arrival.

#### ■ *Collection of Data on Specialized Cardiac Care Services*

MHCC defines specialized cardiac care to include three major services: (1) emergency angioplasty referred to as primary percutaneous coronary intervention (pPCI) services, for certain types of heart attacks or ST elevation myocardial infarctions (STEMIs); (2) elective or non-primary PCI; and, (3) cardiac surgery. There are currently ten Maryland hospitals that offer all three specialized cardiac care services. In addition, thirteen Maryland hospitals without cardiac surgery on-site provide emergency angioplasty services under a waiver program established by the Commission.<sup>1</sup>

MHCC currently collects data on patients receiving specialized cardiac care services and is interested in adopting a standard data set for each category of specialized cardiac care service that will provide high quality and timely data measuring the process and outcomes of care. To that end, the Commission distributed a request for public comment and stakeholder input on alternative approaches to the collection of data on specialized cardiac care services, including primary and non-primary PCI and cardiac surgery services. Comments are due to the Commission by October 23, 2009.

#### ■ *Maryland Quality Measures Data Center Project*

In addition to the activities associated with the immediate update of the Guide, the staff continues to work on the implementation of the Quality Measures Data Center (QMDC). The QMDC will provide a web-

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<sup>1</sup> Nine of these hospitals have been approved by the Commission to participate in a research study of non-primary PCI in hospitals without cardiac surgery on-site.

based tool for hospitals to upload clinical quality measures and patient experience (HCAHPS) data required to be reported to the Commission. This approach will not only accelerate the timely receipt of data directly from hospitals, but it will enable the Commission to validate the accuracy and completeness of the data as well. Staff and the contractor, IFMC, meet weekly to define technical specifications and develop program requirements associated with this new internet based point of access for hospitals to submit their data directly to the Commission. The first quarterly data submission period for 1<sup>st</sup> quarter 2009 clinical measures and HCAHPS data is October 5<sup>th</sup> through October 23<sup>rd</sup>.

On October 1st, the MHCC, held its 2<sup>nd</sup> quarterly QMDC Webinar /Conference Call for hospital representatives to review the new HCAHPS adjustment methodology and preview reports, Childhood Asthma Care data file specifications, and the clinical measures data validation process. Hospital participation in the webinar was high and based on the assessment of the participant evaluation forms; the hospital industry appears to find the quarterly sessions to be beneficial.

### **Healthcare Associated Infections (HAI) Data**

#### ■ *Validation of Data on Central Line-Associated Blood Stream Infections (CLABSI) in the ICU*

Since July 1, 2008, Maryland hospitals have been required to use the National Healthcare Safety Network (NHSN) surveillance system to report data to the Commission on Central Line-Associated Blood Stream Infections (CLABSI) in any ICU. Hospitals are required by NHSN to report data in the system within 30 days following the end of the month. The Commission has collected several months of CLABSI data and plans to conduct an independent quality review of the data prior to public release of the information on the Hospital Guide. To that end, the staff initiated a procurement project to engage the services of a contractor with expertise and experience in the quality review of healthcare infections data. The contractor will perform an assessment of the accuracy and completeness of the Commission's CLABSI data. The procurement process has been completed and staff has initiated a contract with APIC Consulting Services, Inc. to develop and implement a plan to validate the hospital data. The staff held the initial kick off meeting with the contractor on September 1<sup>st</sup> and now holds weekly meetings to facilitate timely completion of the project.

#### ■ *American Recovery and Reinvestment Act (ARRA) Grant Funding*

On September 4, 2009, the Centers for Disease Control and Prevention (CDC) announced the award of a \$1.2 million grant to Maryland under the American Recovery and Reinvestment Act (ARRA) to enhance the prevention of healthcare-associated infections (HAI). The grant is a collaborative effort involving the Department of Health and Mental Hygiene, Maryland Health Quality and Cost Council, and the Maryland Health Care Commission. The funds available under this program will build on the Commission's HAI initiatives and enable Maryland to strengthen its data collection, reporting, and analysis infrastructure to meet the challenge of preventing HAI. The grant will support two Health Policy Analyst positions. The position descriptions have been developed and the position vacancies have been posted for recruitment.

#### ■ *2009-2010 Health Care Workers (HCW) Influenza Vaccination in Hospitals Survey*

Staff distributed the 2<sup>nd</sup> annual Survey on Health Care Workers (HCW) Seasonal Influenza Vaccination to Maryland hospitals. This survey will provide useful information on individual hospital vaccination rates as well as hospital performance in comparison to peer facilities and to the State as a whole. The survey has been enhanced as a result of lessons learned from the pilot survey conducted last year. The online survey will be distributed to hospitals in the spring of 2010 for completion within 30 days following the end of the flu season (May 15, 2010). On September 8<sup>th</sup>, the staff met with representatives from the Maryland Ambulatory Surgery Association to discuss the implementation of the HCW Influenza

Vaccination Survey in ambulatory surgery centers. The staff will continue to work with the organization to facilitate implementation for the upcoming flu season.

■ *Active Surveillance Testing (AST) for MRSA in All ICUs Survey*

The results of the 2<sup>nd</sup> quarterly survey for collecting data on Active Surveillance Testing (AST) for MRSA in All ICUs have been submitted by hospitals. It is important to note that this is a process measure that evaluates the rate of hospital screening (AST) for MRSA in all ICUs. It is not an outcome measure that evaluates the rate of MRSA colonization or infection in the hospital. The results of the survey are under staff review for completeness and will be distributed to hospitals for review prior to public reporting. The 3<sup>rd</sup> quarter MRSA survey has been distributed to hospitals and must be completed by October 30, 2009.

■ *New Surgical Site Infection Data Collection*

Effective January 1, 2010, HAI data reporting requirements for Maryland hospitals will expand to include hip replacement, knee replacement, and coronary artery bypass graft (CABG) Surgical Site Infections (SSI). The National Healthcare Safety Network (NHSN) system will be the vehicle for collecting this HAI data.

■ *Statewide Hand Hygiene Campaign*

At their June 10, 2009 meeting, the Maryland Health Quality and Cost Council adopted a key recommendation from its Evidence-Based Medicine Work Group calling for the implementation of a statewide Hand Hygiene campaign. The Council is chaired by Lieutenant Governor Anthony G. Brown. Department of Health and Mental Hygiene Secretary John M. Colmers serves as Vice Chair of the Council. The Council has prioritized conducting a statewide hand hygiene initiative and prevention of healthcare-associated infections as part of its work plan. To implement this recommendation, the Council requested consultation from the Healthcare-Associated Infections (HAI) Advisory Committee of the Maryland Health Care Commission. In his July 29, 2009 letter to HAI Advisory Committee members, Secretary Colmers requested recommendations from the regarding the guiding principles, methodology, and data collection for a statewide Hand Hygiene campaign to be implemented this fall. On August 31, 2009, the HAI Advisory Committee and its Hand Hygiene and Infection Prevention Subcommittee submitted its *Report and Recommendations on Implementation of a Statewide Hospital Hand Hygiene Campaign* to Secretary Colmers. The Report includes six recommendations:

**Public Education**

**Recommendation 1.** *In conjunction with the statewide hospital Hand Hygiene Campaign, the Maryland Council on Health Quality and Cost, and the Commission's Healthcare-Associated Infections Advisory Committee should develop a public awareness campaign to emphasize the importance of hand hygiene in preventing HAIs, including influenza.*

**Measurement of Hand Hygiene Compliance**

**Recommendation 2.** *The Healthcare-Associated Infections Advisory Committee recommends that hospital hand hygiene programs be supervised by Infection Preventionists.*

**Recommendation 3.** *The Healthcare-Associated Infections Advisory Committee recommends that hospital programs measuring adherence to hand hygiene protocols be required to use trained non-Infection Preventionist staff to conduct observations.*

**Recommendation 4.** *The Healthcare-Associated Infections Advisory Committee recommends that hospital programs measuring adherence to hand hygiene protocols be required to use*

*trained observers to perform data collection. A formal, statewide program should be developed to train observers to ensure the collection of consistent and reliable data on hand hygiene adherence.*

**Recommendation 5.** *The Healthcare-Associated Infections Advisory Committee recommends that hospital programs be required initially, at a minimum, to collect data on adherence to hand hygiene protocols: after touching a patient or touching a patient's surroundings; by major discipline of health care worker, including nurses, physicians, environmental services, food services, and ancillary support staff who enter patient environments; and, for inpatient and intensive care units and the emergency department. There should be a minimum of 30 observations per month for each unit.*

#### **Data Collection and Implementation**

**Recommendation 6.** *The Healthcare-Associated Infections Advisory Committee and its Hand Hygiene and Prevention Subcommittee should work with the Maryland Patient Safety Center (MPSC) to implement a statewide Hand Hygiene Campaign. The MPSC: should identify a limited number (e.g., 2-3) of existing tools that could be used to support a statewide hand hygiene campaign; develop a common approach to calculate adherence rates that provides comparable data across hospitals; define the minimum number of inpatient units to be reported by each hospital; and, develop a training program to support the collection of valid hand hygiene compliance data.*

#### **Other Activities**

In support of MHCC's hospital quality initiatives, the staff continues to reach out to other units within DHMH, federal agencies, professional organizations and other states, to share and gather information and to identify opportunities for collaboration and improvement. The staff continues to collaborate with the HSCRC staff on data issues to support the Quality Based Reimbursement project and broader rate setting issues.

#### ***Specialized Services Policy and Planning***

On September 29, 2009, the Commission convened a meeting of the 13 hospitals with primary percutaneous coronary intervention (pPCI) waivers, along with the Medical Director and Senior Nurse Manager of the STEMI Registry, to discuss clinical and data management issues. Also in attendance were Lisa Myers, RN, MS, Director of Special Programs, Maryland Institute for Emergency Medical Services Systems (MIEMSS), and Rhonda Ford Chatmon, Senior Director, Alliances & Health Integration, Greater Washington Region and Maryland, American Heart Association/American Stroke Association. Held at Frederick Memorial Hospital (FMH), the work session included a summary of January to June 2009 data from the Commission's STEMI Registry; a presentation on the door-to-balloon times achieved by FMH's start-up pPCI program, including its "Code Heart" workflow and the LIFENET System for 12-lead ECG transmission; a presentation on regionalization and coronary artery disease; an update on the consensus-building process begun by MIEMSS to designate hospitals as cardiac (interventional) centers; and information from the American Heart Association (AHA) about Mission: Lifeline, AHA's national initiative to improve the systems of care for patients with ST-segment elevation myocardial infarction (STEMI).

Based on the current schedule for receipt of applications for a waiver to provide pPCI services without on-site cardiac surgery, the following hospitals with two-year pPCI waivers must file renewal applications on October 7, 2009: Holy Cross Hospital, Howard County General Hospital, Johns Hopkins Bayview Medical Center, and Saint Agnes Hospital.

## **CENTER FOR HEALTH INFORMATION TECHNOLOGY**

### **Health Information Technology**

Preliminary findings indicate that more than half of the freestanding ambulatory centers in Maryland use software applications to manage their patient workflow. The survey was incorporated into the annual *Maryland Freestanding Ambulatory Surgical Center (FASC) Survey* and is similar to the *Hospital Health Information Technology Survey* conducted last fall. The survey assessed the adoption of health information technology (HIT) in seven leading core areas, such as computerized physician order entry (CPOE) and electronic health records (EHRs), which has the potential to improve patient safety and the quality and efficiency of care delivery. Staff will present findings from the FASC survey in an information brief scheduled for release around the end of the year. Staff is preparing to release the second annual *Hospital HIT Survey* that assesses HIT adoption in Maryland's 47 acute care hospitals. A report on this survey is expected for release in the spring of 2010.

Staff convened a multi-stakeholder meeting to explore incentives that payers can offer in compliance with House Bill 706 (HB 706) – *Electronic Health Record – Regulation and Reimbursement*, signed into law on May 19<sup>th</sup> by Governor Martin O'Malley. Maryland is the first state to build on the Medicare and Medicaid adoption incentives under the *American Recovery and Reinvestment Act of 2009* (ARRA), requiring state-regulated payers to provide incentives for the adoption of EHRs. The law requires state-regulated payers to provide monetary incentives for the adoption and meaningful use of EHRs beginning in 2011. Staff notified payers of their intent to request a formal plan that outlines what they have in mind that would qualify as an incentive under the law and to provide a list of items they would like the MHCC to consider in developing regulations. An update on the development of the regulations is due to the legislature in January.

Staff finalized the State Health IT Plan (state plan) to comply with the recent guidance received from the Office of the National Coordinator for Health Information Technology (ONC). Changes in the state plan were required in order for Maryland to meet the criteria for a health IT implementation funding grant. ONC requires a detailed strategic and operational plan on how the state plans to implement health IT as part of the funding application. The state plan details an approach to HIE that will support high quality, safe, and effective health care; makes certain that data is exchanged privately and securely; ensures transparency and stakeholder inclusion; supports connectivity regionally and nationally; achieves financial sustainability; and serves as the foundation for transforming health care in Maryland. The state plan is a required component of the *State Health Information Exchange Cooperative Agreement Program* grant that is due by October 16, 2009.

Staff released the second version of the web-based EHR Product Portfolio (portfolio) in September. Included in the portfolio is a list of certified vendors that have agreed to offer product discounts and a five year pricing structure, posting of consumer reports based upon feedback from five references, and policies related to privacy and security. Vendor products listed in the portfolio have met the most stringent Certification Commission for Health Care Information Technology (CCHIT) certification standards relating to functionality and security; new to this version is the requirement that vendors meet the CCHIT interoperability requirements. The portfolio is updated semi-annually and all CCHIT vendors are invited to participate. Staff is currently developing a portfolio that includes information on EHRs for nursing homes. The portfolio will include similar information to what currently exists. Staff will work with vendors and representatives from nursing homes to finalize the portfolio and expects to release it around the end of the year.

The Centers for Medicare and Medicaid Services (CMS) EHR Demonstration Project has been underway for the last several months. Staff continues to provide physicians participating in the treatment group with information on EHRs. Outreach efforts have primarily focused on practices that have not

implemented an EHR; these practices must implement an EHR prior to July 2010 in order to qualify for incentives under the program. Approximately 127 small to medium sized primary care physician practices specializing in family practice, general practice, internal medicine, and gerontology are participating in the treatment group. Over a five year period, participants are eligible to receive up to \$290,000 in monetary incentives for adopting EHRs and reporting on 26 quality measures for four medical conditions over a five year period. Maryland is one of four states participating in this project.

### **Health Information Exchange**

In August, the Health Services Cost Review Commission approved the MHCC Commissioner's recommendation to fund the Chesapeake Regional Information System for our Patients (CRISP) for up to \$10 million in funding. Last month, representatives were selected to participate on the following CRISP Advisory Board Committees: Exchange Technology Committee, Clinical Excellence and Exchange Services Committee, and Finance Committee. The Exchange Technology Committee met for the first time in September. The other two committees are tentatively scheduled to meet in October. The Policy Board is predominately consumer based, includes business, provider, and payer representatives and expects to meet in December. The Policy Board will develop policies related to privacy and security consumer authorization and consent, minimum criteria for user authentication, minimum requirements for role-based authorization, security requirements, and audit trail requirements.

The ONC released two health IT grant applications under the ARRA on August 20<sup>th</sup>. Staff completed the first draft of the application for the *State Health Information Exchange Cooperative Agreement Program* in September, and is on schedule to meet the October 16<sup>th</sup> application due date. This grant will improve and expand HIE services to reach all providers in an effort to improve the quality and efficiency of health care. ONC advised staff that \$9,313,924 has been appropriated for Maryland. The other grant, *Health Information Technology Extension Programs: Regional Centers Cooperative Agreement Program*, will fund a non-profit entity to provide education, awareness, and technical assistance for the adoption and meaningful use of EHRs. The average funding award for recipients of the grant is approximately \$8.5 million. MHCC received notification from ONC that the preliminary application developed in collaboration with CRISP has been approved. The full application is due to ONC by November 3<sup>rd</sup>.

Staff continues to provide support to the Electronic Healthcare Network Accreditation Commission's (EHNAC) Health Information Exchange (HIE) Policy Accreditation Advisory Panel (panel). The panel works with stakeholders across the nation to develop a policy accreditation program that validates HIEs which have in place a minimal set of policies safeguarding the privacy and security of electronic health information. In September, members of the panel met to develop a testing strategy for the existing draft criteria and to identify additional policies that need to be included in the criteria. EHNAC plans to pilot the draft criteria with the Utah Health Information Network (UHN) in December. UHN is an administrative electronic health network that recently launched a clinical messaging application. EHNAC has engaged a consultant to assist in disseminating the draft criteria with additional policy experts with the expectation of obtaining additional enhancements to the draft criteria. EHNAC anticipates that the HIE policy accreditation program will be available in the first quarter of 2010.

Staff collaborated with the Maryland Insurance Administration (MIA) to develop a modification to their existing regulation, COMAR 31.10.12 *Uniform Consultation Referral Form*. These regulations currently restrict the electronic transmission of the referral form directly from an EHR system. Staff worked with a group of physicians to craft language that would enable providers to transmit the form without manual intervention. The proposed language received favorable support from the large payers in the state. The MIA expects to formally consider promulgating regulations with the proposed changes in October.

Staff is currently updating the *HIPAA: A Guide to Privacy Readiness* based on the 13 revisions that were included in the ARRA that directly impact on the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Leading changes required to the guides pertain to business associates, information breaches, and inadvertent disclosure of personal health information. Staff originally developed the guide

to help small practices conduct a privacy and security gap assessment in compliance with the HIPAA Administrative Simplification provisions. Staff expects to complete the revisions by the end of the year.

### **Electronic Health Networks & Electronic Data Interchange**

Staff continues to analyze the data from the *2009 Annual EDI Progress Report*. Completion of the data analysis is targeted for the end of October. COMAR 10.25.09, *Requirements for Payers to Designate Electronic Health Networks*, requires payers with a premium volume of over \$1 million or more to report each year on their volume of administrative health care transactions. Staff uses this information to develop an *EDI Progress Report* that is used each year by payers and provider organizations to develop strategies to increase the use of technology. The report will include information from 44 payers, including Medicare, Medicaid, and seven Medicaid Managed Care Organizations. This year's report is scheduled for release in early 2010.

Electronic health network certification (network) activity for the month included recertification of Emdeon and Caprio (formerly MedAvant) and initial certification to Vision Share. COMAR 10.25.07, *Certification of Electronic Networks and Medical Claims Clearinghouses* requires payers doing business in the state to accept electronic health care transactions from only MHCC certified networks. Network certification is required every two years and is based on obtaining EHNAC accreditation and a staff review of the network's privacy and security policies. Staff anticipates that up to 23 e-prescribing networks may seek certification as a result of Board of Pharmacy's proposed regulations, COMAR 10.34.20, *Format of Prescription Transmission* that requires pharmacies to use MHCC certified networks.

### **National Networking**

Staff participated in the HIT Standards Committee where the meaningful use quality measure grid was discussed and an update provided. A report from the Privacy and Security Workgroup was given regarding the implementation specification recommendations. Staff also attended the day long HIT Policy Committee meeting held by the ONC. Among other things, this event provided a review of privacy and security policy issues and a discussion on secondary uses of data. Staff participated in a technical assistance conference call regarding the *State HIE Cooperative Agreement Program* that highlighted several key features of the program and available support from ONC.

Staff participated in several webinars during the month: *Health Data Management ARRA Update II: What It Means To Your Healthcare Organization* that presented the Eclipsys path for organizations to best position themselves to qualify for ARRA funding; *eHealth Initiative Understanding State and National Health Information Technology Policy* that presented an in depth discussion of the HITECH legislation; *HIMSS HIT in the Next Five Years: Managing the Mandates of 5010/ICD-10, ARRA, Privacy and Security and Healthcare Reform* that reviewed the impact from 5010/ICD-10, ARRA meaningful use and the HIPAA privacy and security changes.